First Health Services Corporation

Mental Health Drug Authorization Request Form for Atypical Antipsychotic Agents - *Not to be used for requesting other agents*

Fax form must be filled out completely for consideration of request

FAX to **800-453-2273** (toll tree)

SUBMITTED BY: [ ] Prescriber [ ] Pharmacy

(MAP-82101, revised 5/15/07)

RECIPIENT NAME	MAID # (10 digits)	DATE OF BIRTH
	_ _ _ _ _ _ _ _ _ _	

First Health is directed to FAX a response to the following fax number (s):	*Prescriber Fax # (Print Clearly)*	and / or	*Pharmacy Fax # (Print Clearly)*

	PRESCRIBER Information	PHARMACY Information	
Name			
Specialty			
Phone #			
State License# or NPI # *(no DEA #)*		**NPI #** *(no DEA #)*	

	Drug Requested (Use separate form to request more than 3 drugs)	**Dosage Form**	**Strength**	**Quantity**	**Directions for use**	**Start Date for this PA**	**National Drug Code (if known)**
1							
2							
3							

PERTINENT DIAGNOSES (INCLUDING ICD – 9 CODES: Refer to website http://Kentucky.fhsc.com, select PROVIDERS, then select "PHARMACY PROVIDER NOTICE #011 – 2/8/05" for approvable ICD – 9 diagnosis codes) _____

[ ] MEDICATION TO BE USED FOR UNLABLED USE *(if checked, please explain)* _____

_____

CURRENT MEDICATIONS _____

_____

[ ] PATIENT RECENTLY HOSPITALIZED *If checked, please provide hospitalization dates and discharge dosages of Atypical Antipsychotic medications in table below.*

MEDICAL JUSTIFICATION *(include drugs already tried in table below)* _____

_____

ATYPICAL ANTIPSYCHOTIC THERAPY (List of pertinent information regarding all Atypical Antipsychotics previously or currently used as reflected by documentation in physician's chart or recent hospitalization	**DOSAGE FORM**	**STRENGTH**	**DIRECTIONS FOR USE**	**DATE TREATMENT STARTED or date when hospitalized**	**DATE TREATMENT ENDED or date discharged from hospital**